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Reproductive Health Update 2004

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Table of contents

Executive Summary……………..…………………………………………………3

Introduction…………………………………………………………………….……3

1. Maternal Mortality- 5 jumbo jet crashes per day…………………………..……4

2. Preventing unsafe abortions by offering comprehensive RH services ………7

Good Practice Examples…………………………………………..……….……11

References and further Resources…………………..……………..…….……12

List of abbreviations

CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women	**SCIH**	Swiss Centre for International Health
ECA	Economic Commission for Africa	**SDC**	Swiss Agency for Development and Cooperation
EmOC	Emergency Obstetric Care	**SRH**	Sexual and Reproductive Health
GGR	Global Gag Rule	**STI**	Swiss Tropical Institute
GTZ	German Technical Cooperation Gemeinschaft für Technische Zusammenarbeit	**TBA**	Traditional Birth Attendants
HSR	Health Sector Reform	**UNDP**	United Nations Development Programme
ICASA	International Conference on AIDS and Sexually Transmitted Infections in Africa	**UNFPA**	United Nations Agency for Population Affairs
ICPD	International Conference on Population and Development	**UNICEF**	United Nations Children's Fund
JHPIEGO	John Hopkins Programme for International Education in Reproductive Health	**USAID**	United States Agency for International Development
MDG	Millennium Development Goals	**VCT**	Voluntary Counselling and Testing
NGO	Non Governmental Organisation	**WHO**	World Health Organisation
PAC	Postabortion Care		
PAHO	Pan American Health Organisation		
RH	Reproductive Health		

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Executive Summary

Improving maternal health and reducing maternal mortality is one of the Millennium Development Goals and a priority of the World Health Assembly. Every minute one woman dies in the course of pregnancy or childbirth, 89% of which occurs in developing countries. Overall, progress to reduce maternal mortality has been much slower than envisaged at the ICPD and pregnancy and childbirth are still the leading causes of death among young women in developing countries. There has been progress in some areas, such as provision of antenatal care, and in addressing population concerns in general. In regard to Safe Motherhood interventions in particular, reviews are mixed. There has been deterioration in some areas and financial resources and commitments by donor countries are clearly insufficient to meet the goals set by the ICPD. This is in spite of the proven cost-effectiveness of Safe Motherhood interventions and progress in identification of determinants and effective interventions to reduce maternal mortality. These include increasing the number of births attended by skilled professionals, the maintenance of reliable referral systems and strengthening reproductive health systems overall. Research and practice have shown that the presence of traditional birth attendants during delivery have not produced expected outcomes. Consequently, the focus has shifted back to increasing skilled birth attendance.

One of the main preventable causes of maternal mortality is unsafe abortions. In some countries it is the most common cause of maternal death and poses a high financial burden on health systems. It can, however significantly be reduced through access to comprehensive reproductive health services, choice of family planning services and legalisation of abortion. Experience has shown that legalisation does not lead to increased rates of abortion. In general, abortion policies vary widely from country to country. In many countries legalising abortion is still highly politicised with strong movements against it. In 2003 a first meeting to discuss unsafe abortion led by WHO was held in Africa. The primary message of this paper is that the main priority is to prevent unwanted pregnancies. In countries where the termination of pregnancy is legal, the emphasis should be upon the provision of safe abortions.

Introduction

RH is one of SDC's priorities in health.

This update aims to provide information that can help SDC collaborators, partners and other actors to make informed decisions regarding maternal mortality and unsafe abortions, both important issues within the field of Reproductive Health (RH). **Reproductive Health** is **considered to be an essential prerequisite for reaching the Millennium Development Goals.** The Swiss Agency for Development and Cooperation, (SDC) has declared the promotion of reproductive health and reproductive rights to be one of five priorities in its newly established health policy. This commitment is based on the acknowledgement that **SDC's priority countries are greatly affected by the burden of poor reproductive health**. Reproductive and sexual ill-health accounts for 20% of the global burden of ill-health for women and 14% for men (WHO, May 2004).

For several years, the agency has produced regular updates in order to inform its collaborators and partners about new developments and ongoing discussions in the field of sexual and reproductive health (SRH). Former RH updates can be downloaded from www.sdc-

health.ch in the document/improving RH section.

The current update includes:

- An update on the problem of Maternal Mortality
- A focus on preventing unsafe abortions

Improving maternal health and reducing maternal mortality is one of the MDGs and a priority of the World Health Assembly.

The fifth of the 8 **Millennium Development Goals** is to improve maternal health, measured by a target of **reducing by three quarters the maternal mortality ratio.** The **World Health Assembly** has very recently (WHO, May 2004) adopted its first global strategy on reproductive health. **Improving antenatal, delivery and postpartum care is one of five targeted priority aspects**. Today relatively simple and cost-effective interventions are available that could effectively prevent maternal mortality. Even so, maternal mortality remains unacceptably high in most of the developing world. **Much of this mortality is caused by women resorting to unsafe abortions** of an unwanted pregnancy - often as a consequence of lack of access to a full range of appropriate family planning services and access to information. Today the issue of **preventing unsafe abortions is highly politicised and considered taboo by certain governments** and fundamentalist groups. These campaigns have the countrerproductive effect that RH services overall are weakened, resulting in even less access to services for those most in need and pushing women from preventing unwanted pregnancies or safe abortion –in countries where the law allows them- into **unsafe abortions that risk women's lives**.

Unsafe abortions cause much of the preventable maternal mortality.

Access to comprehensive RH services and legalisation reduce rates of unsafe abortion.

This update does not promote abortion. We primarily want to show that **improving comprehensive RH services and a liberalisation around the issue of abortion have proven to reduce and not increase the rates of abortion**, not only those that are unsafe.

1. Maternal Mortality- 5 jumbo jet crashes per day

Every minute one woman dies in the course of pregnancy or childbirth, 89% of which is in developing countries.

Pregnancy and childbirth claim the lives of an estimated 529'000 women every year. (WHO, 2004) This translates into one woman dying on this planet every minute. The overwhelming **majority of these deaths (89 percent) occurs in the developing world** where for every 100'000 live births, 480 women die. This is an equivalent of 5 747 jumbo jets crashing each day. The risk of **dying of pregnancy or childbirth in Africa in a woman's lifetime is 1/17 compared to 1/1800 in developed countries** making maternal mortality the indicator with the widest range between developing and developed countries.

Nearly two thirds of maternal deaths worldwide are due to five direct causes:

- severe bleeding (24%)
- infection (15%)
- unsafe abortion (13%)
- eclampsia (pregnancy-induced hypertension, 12%)
- obstructed labour (8%)

The other third of maternal death are due to indirect causes such as malaria, anaemia, hepatitis, and increasingly AIDS. About 15 per cent of all pregnancies will result in complications of which many, if untreated, will be fatal. **For every woman who dies, an estimated 15 to 30 women suffer from chronic illnesses or injuries** related to their pregnancies, such as uterine prolapse, fistulae, incontinence or pain during intercourse and infertility.

ICPD + 10: Has the situation improved over the last ten years?

Since the International Conference on Development and Population (ICPD) in 1994 there have been a number of further milestones that have provided opportunities for reflection, such as the **ICPD+5 Review of Progress** in 1999. In March 2004, the United Nations Commission on Population and Development met to assess progress made during the first 10 years of the Cairo Program of Action (**ICPD + 10**).[1] The UN General Assembly stated that, despite the clarity of the ICPD mandate, **progress has been limited and much slower than envisaged in 1994**. In many countries legal abortion services are still often neither safe nor accessible, and access to contraception remains inadequate. The **situation even became worse in some regions**. For example **in Africa maternal mortality has increased** from 870/100'000 live births in 1990 to 1000/100'000 in 2001. In Afghanistan, which has one of the highest maternal mortality rates worldwide (1,600/100,000), still more than 90 per cent of women are giving birth without a skilled birth attendant. According to a report by Save the Children (State of the World's Mothers 2004), pregnancy and childbirth are **still the leading cause of death among girls and young women** aged 15 to 19 in the developing world.

Since ICPD: Progress much slower than envisaged, pregnancy and childbirth still leading cause of death among young women in developing countries

According to the new report by UNDP, **lack of financial resources** is one of the greatest threats to progress, more than **80 per cent of countries** reported that available resources did not meet needs to adequately address the objectives defined in Cairo. In addition, as stated within the same survey, current financial commitments by donor countries to poorer states are inadequate to make the Cairo vision a reality. "The equivalent of slightly more than one day's worldwide military spending would be enough to close Cairo's $3 billion external funding gap."

Financial resources and commitments by donor countries are lacking.

Apart from the lack of funding, main reasons for the slow success in reducing maternal mortality rates appear to be related to the **complex political and social issues related to poverty and the status of women.**

Despite the mixed reviews of ICPD+10, there are reasons to be optimistic. **Safe Motherhood interventions are amongst the most cost effective prevention measures available** and it is well known today which are the interventions needed. In Europe and North America which once had levels of maternal mortality comparable to those in the developing world today, maternal mortality rates have been reduced between 1900 and 1980 to almost zero. Sri-Lanka and Thailand drastically reduced maternal mortality rates within 20 years (1980-2000). **Overall, the number of pregnant women in developing countries receiving antenatal care**

Safe Motherhood interventions are highly cost effective.

Provision of

[1] Investing in People: National Progress in Implementing the ICPD Programme of Action 1994-2004., UNFPA, http://www.unfpa.org/icpd.

antenatal care has increased, and there has been progress in addressing population concerns.

has increased by about 20 per cent since 1990. Progress has been greatest in Asia, with a 31 per cent increase in access to antenatal care. Also, when looking at population issues in general, progress has been made over the last decade. According to a report released by the Economic Commission for Africa (ECA), **96 per cent of African countries have integrated population concerns into their development agenda**, as compared to only 25 per cent in 1994.

<u>Interventions that can make a difference</u>

MMR can be reduced most effectively by birth attendance and by skilled professional, reliable referral and strengthened reproductive health systems.

Most developing countries that have experienced success with programmes to reduce Maternal Mortality Rates (MMR) promoted a **gradual shift to professional attendance at birth and a move towards facility-based deliveries**. In China, Cuba, Malaysia and Sri Lanka for example, where maternal mortality rates are comparatively low, the entire health-care delivery system has been strengthened, with a **high proportion of births attended by a skilled professional and a reliable referral system for complicated deliveries.** Also, in most of these countries, **health services are offered either free or at very low cost**. In Sri Lanka, another intervention to reduce maternal mortality has been **improving family planning** services to prevent early and closely spaced pregnancies (Modern contraceptive prevalence rate 44%). In Malaysia, introducing confidential maternal death audits to **identify preventable causes of maternal deaths** contributed to a decline in maternal mortality. Conversely, in Zimbabwe a progressive erosion of the general standard of health services and predominance of user fees have been associated with rising maternal mortality. As **accessibility and functioning of health services** is such a **direct determinant**, it has even been **proposed to use maternal mortality as an indicator to assess health systems**.

A main challenge with maternal mortality is that **complications related to pregnancies are extremely difficult to predict** at the population-level. Even in developed countries, prediction is generally limited to identifying high-risk groups of women. Therefore, the focus for addressing maternal mortality has **shifted from predicting complications during pregnancy to preparing for efficient emergency interventions**. In general, **emergency obstetric interventions are inexpensive** and can easily be carried out by specially trained health professionals, but they do **require a functioning referral system** which especially in developing countries constitutes a main obstacle. A study in Nicaragua, for example, showed that insufficient telephone and radio communications, as well as a limited number of ambulances, impedes effective referral and transfer of patients with obstetric emergencies.

Much discussion has been around the **issue of skilled attendance at birth vs. involving traditional birth attendants.**[2] While some small projects have had **success in training TBAs, evaluations results reveal**

[2] Skilled attendance refers to professionally trained health workers (normally a doctor, midwife or nurse) with the respective skills to manage a normal delivery and diagnose or refer obstetric complications. Trained and untrained traditional birth attendants (TBAs) are not included in this category.

Interventions with TBAs alone do not lead to expected outcomes.

The focus is back to increasing skilled attendance during delivery.

no significant reduction in maternal mortality. This can partly be attributed to the **lack of well-trained medical staff and functioning referral services** needed to backup TBAs if complications arise. Until now, only 53% of deliveries in developing countries take place with the assistance of a skilled birth attendant. Following recommendations by WHO, the **focus has therefore shifted back to increasing skilled attendance during delivery**. TBAs, however, are still considered to have a role, for example, with regard to bridging the gap between communities and trained health providers or encouraging women to use family planning, antenatal services and to get Emergency Obstetric Care (EmOC) at health facilities should complications arise.

Given that RH is **intrinsically linked with social and cultural norms and attitudes**, **community involvement** is an essential part of maternal health programmes. In Cambodia for example UNFPA has made use of the existing system of "Health Centre Feedback Committees", where village representatives meet on a monthly basis to give feedback to local health centres, to provide community safe motherhood education.

Measuring Progress, Research issues

Data to measure maternal mortality is **difficult and expensive to obtain** and are often inaccurate in many poor countries with limited vital registration systems. Maternal mortality is **likely to be underestimated** even in countries with good vital registration systems. As an alternative, **process indicators** are used.[3] These indicators give a **picture of the availability, quality and use of services.**

Measuring Maternal Mortality difficult, process indicators used to assess interventions and functioning of health services

In a comprehensive regional project, a needs assessment supported by UNFPA evaluated emergency obstetric care in eight sub-Saharan countries (one of which is Niger). Services were assessed according to availability, utilization, and quality to indicate progress with regard to building capacity and increase of available health services.[4] Results from multi-stakeholder workshops are now shared with other countries.

In the newly-independent States of the former Soviet Union, although vital registration systems are comprehensive, they share a common **history of underreporting and misclassification of deaths**. The Ukraine and Tajikistan are just two of SDC's partner countries, where such difficulties have been encountered. Especially in Central Asia there is relatively little published research available on maternal mortality and its determinants. Estimates range from about 25 maternal deaths per 100,000 live births in Ukraine up to 50/100,000 live births in Kazakhstan in 2001, compared to about 6/100,000 in the EU.

2. Preventing unsafe abortions by offering comprehensive RH services

Unsafe abortion is in some countries the most common cause of maternal death and poses a high financial burden on health systems.

Each year, there are 75 million unwanted pregnancies worldwide, resulting in approximately 20 million unsafe abortions[5] (18,5 of them in developing countries), and nearly 80,000 maternal deaths. Unsafe abortion accounts for **at least 13% of maternal mortality worldwide and in some countries such as Afghanistan it is the most common cause of maternal death**. Complications resulting from unsafe abortion can place a **high financial burden on health systems** taking up as much as **50% of some hospital budgets** in developing countries. In Tanzania for example, it was found that 34% to 57% of all admissions to the gynecological ward of a hospital in Dar es Salaam resulted from complications of abortion. More than half of these unsafe abortions were among young women aged 15-24, who often have poor access to family planning information and services and are less likely to have the social contacts and means to obtain a safe abortion. In many African countries, **up to 70% of all women hospitalized** for abortion complications are **younger than 20**. On the other hand, unsafe abortion, and the death and injury it causes, is **almost entirely preventable**. When performed by a skilled provider under safe conditions and with modern methods, abortion is one of the safest surgical procedures.

Abortions are generally more unsafe in private clinics which are not registered and do not follow national standards

In countries where abortion is legal, **unsafe abortions in private clinics** pose an increasing challenge. Such private clinics do not always follow national quality standards and abortion is often performed in unsafe circumstances. But, with growing stigmatization of women who undergo an abortion, in Kyrgyzstan, for example, many young girls choose private clinics to avoid notification. In one province in Kyrgyzstan, death due to abortion has increased 3.5 times over the past year.

For 33 years, India has had **legal abortion** and policy aimed at **setting basic standards**. However, private, unregistered clinics are thriving, with legal abortion facilities accounting for only 24 per cent of abortions nationally. Supply of private facilities is triggered mainly due to financial incentives of providers. Despite their lack of standards and quality, they flourish mainly as there is more anonymity in the private sector and a general belief that the public sector is serving the poor.

ICPD + 10: Has the situation improved over the past 10 years?

Overview of worldwide abortion policies

The relevant ICPD recommendations emphasize the expansion of life-saving post-abortion care (PAC) and the provision of technical and policy guidance for health systems. **Legal frameworks and policies on abortion vary widely from country to country.** 89% of developed countries and 52% of developing countries consider protection of women's health as a basis for legal abortions, but definitions of what is considered a legitimate risk to health are diverse. **In some countries danger to a**

Abortion poli-

[3] Useful process indicators are for example the percentage of deliveries with skilled attendants, the number of facilities offering EmOC and their geographic distribution or the Caesarean-section and case fatality rates. A main indicator to measure progress with regard to the Millennium Development Goals is the proportion of births attended by a professionally trained and skilled attendant.

[4] For each country, six indicators were produced, following the methodology described in the UNICEF/WHO/UNFPA guidelines issued in 1997, *Monitoring the Availability and Use of Obstetric Services.*

[5] WHO defines unsafe abortion as a procedure for terminating an unintended pregnancy either by persons lacking the necessary skills or in an environment lacking the minimal medical standards, or both.

cies vary widely. In many countries legalising abortion is still highly politicised with strong movements against it.

woman's life is not yet recognized as a legal basis for terminating pregnancy. Since ICPD, a number of countries have reformed their laws to permit women to end unwanted pregnancies under certain circumstances. These include: **Albania** (1996), **Benin** (2003), Burkina Faso (1996), Cambodia (1997), **Chad** (2002), **Mali** (2002), **Nepal** (2002) and **South Africa** (1996). Conversely, other countries have further restricted abortion. In 1997, El Salvador and Poland, for example, passed laws restricting access to abortion services. Also, in some countries with more liberal laws, such as the United States, Hungary and Russia, there are **strong social and political movements working to inhibit women's access to safe abortion services**. The Global Gag Rule (GGR), enacted by the Bush Administration in 2001, denies U.S. funding to non-American NGOs that include abortion care, referral or counseling within their family-planning programs, even if those services are financed by their own resources. **Hundreds of NGOs in countries worldwide are affected by this policy**, having to cut their reproductive health services, including family planning.

In 2003 the first meeting to discuss unsafe abortion led by WHO was held in Africa

But there have been other policy statements which promote the goals set within ICPD. The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) in 1999 defined it as discriminatory for a state to refuse to legally provide for the performance of certain reproductive health services for women. In 2003, WHO issued "Safe abortion: technical and policy guidance for health systems", introduced at the first ever African meeting to discuss unsafe abortion held in Ethiopia.

Restrictive legislation is associated with higher rates of unsafe abortion and correspondingly high mortality

Evidence shows that **restrictive legislation is associated with higher rates of unsafe abortion and correspondingly high mortality**. In Kenya for example, the law allows abortion only when a woman's life is at risk. At the same time illegal abortions – most of them unsafe – are frequently performed. The Kenyan Ministry of Health has indicated that the government's preparatory reports for ICPD have avoided discussing the subject of abortion and potential solutions to the problem of unsafe abortion. This was attributed to the doubling of abortion cases within the last 10 years between 1994 and 2004. In **Romania**, abortion-related deaths increased sharply when the law became very restrictive in 1966, and fell after 1990 when legislation returned to being less restrictive.

Experience in countries that legalized abortion shows that this did not lead to increased abortion rates

The Netherlands, having introduced a non-restrictive abortion law, widely accessible contraceptives and free abortion services, has one of the lowest abortion rates in the world. A study analyzing abortion trends revealed that in Spain, decriminalization had no observed effect on abortion, but only shifted the number of Spanish women who previously aborted in England and the Netherlands (204,736 in 1985) back to Spain. There are many other countries where abortion laws have been changed to **allow greater access to legal abortion without resulting in increased abortion rates** such Barbados, Tunisia and Turkey. But legalization is still not an option in many countries. In Latin America and the Caribbean, where no country has legalized abortion, 95% of all **abortions are illegal with the incidence of unsafe abortion being higher than in any other region** in the world. This results in relatively high maternal mortality rates, with a large proportion of deaths (21%) resulting from unsafe abortion.

While legalization of abortion appears to be one step to prevent unsafe abortion, priority should always be on prevention. If abortions are legal, they should be safe. Besides the legal framework, the **rate of unsafe abortions crucially depends on other issues such as access to family planning and quality of delivery services.**

The first priority is preventing unwanted pregnancies. In addition, in countries where they are legal, abortions should be safe,.

Although availability and choice of family planning services have improved considerably, there is still a great unmet need associated with unwanted pregnancies. In eight of 21 countries surveyed in sub-Saharan Africa, fewer than half of all married women knew where to obtain modern contraception. In **Nepal**, 36 per cent of married teenagers do not have access to family planning. In Zambia, 78% of women treated for abortion complications indicated they wanted to receive information about family planning. Misuse and nonuse of contraception is often due to **poor information, inadequate discussion of client's needs and health conditions, and limited choice of appropriate methods**. Also, in many settings, **adolescents and unmarried women are often prevented or discouraged from using contraception**.

Availability and choice of family planning services correlates with low unsafe abortion.

In the former Soviet bloc, for several decades, there has been a reliance on abortion, which was generally legal, as a means of birth control. **Abortion rates sharply declined after the introduction of family planning and reproductive health services in the 1990s**. Although there has been remarkable change in a relatively short period, abortion rates currently still range from 0.6 per woman in Uzbekistan to 3.7 per woman in Georgia which is one of the highest rates in the world und probably still higher due to underreporting in the governments' statistics (Current abortion rates for: Ukraine: 1.6, Kyrgyzstan: 1.5, Romania: 2.2, Moldova: 1.3). In some countries modern contraceptives are still difficult to obtain, of poor quality, and not promoted by policymakers or the medical community, the latter having a biased interest due to the additional income generated through abortion services. Governments, donor agencies and NGOs have helped to increase use of modern contraception, but in several countries, such as Romania and the Caucasus countries, traditional methods still account for more than half of all contraceptive use. Surveys show a **correlation between low use of modern contraception and abortion**, and the higher the ratio of traditional methods to all methods used, the higher the level of abortion tends to be.

This situation demonstrates that, as mentioned before, **abortion should not be promoted as a method of family planning.** To summarize, requirements for the prevention of unsafe abortion include:

- universal access to family planning with a choice of methods and better quality of services
- an increase in safe abortion services with guidance on the management of complications of unsafe abortion
- improved quality and accessibility of post-abortion care
- education of communities about reproductive health and unsafe abortion
- evidence-based technical and policy guidance to protect women's reproductive health

Good practice examples

Indonesia: Maternal and Neonatal Health Programme

With its Maternal and Neonatal Health Programme, Indonesia (MNH) was able to curb maternal mortality by 17 per cent. According to the Ministry of Health, the declines are primarily attributed to an increase in the number of trained midwives. The programme, funded by USAID and carried out by the Ministry of Health and JHPIEGO, was first implemented in West Java Province at locations that were considered sufficiently large in terms of population, yet lagged behind with high rates of maternal mortality. The programme mainly worked on improving performance and quality of services, and included behavioural change interventions and employed advocacy to address the policy level. As a result of the programme, in 2003, 61,000 midwives were spread throughout the country. This led to an increase of the number of births attended by skilled professionals from 43.2 per cent in 1997 to 66.2 per cent in 2003. Partly due to a strong advocacy element within the programme, it has been replicated in East Java, North and South Sumatra, South Kalimantan and West Nusa Tanggara.

Source: Push Journal, 18/May/04, Best Practice Compendium For Family Planning & Reproductive Health, Advance Africa, Best Practice Unit

Abortion Law Reform: Experiences from Nepal

Nepal achieved reform of its abortion law in 2002, through the actions of diverse stakeholders, including the medical profession, advocacy NGOs, government agencies and international agencies. Initiatives in Nepal to change abortion laws were based on the need to address maternal mortality, recognizing that unsafe abortions were a main contributor. Another reason for advocating the liberalisation of the abortion law was the fact that in cases of abortion women were targeted for trial and often jailed for long periods, but rarely those who carried out the abortion or forced them into an unwanted pregnancy. Nepal has one of the highest maternal mortality rates in South Asia (540 per 100,000), due both to the low social status of women and their lack of access to health care and appropriate family planning. It is estimated that 54% of obstetric hospital admissions and 20% of maternal deaths are due to unsafe abortion. This does not include the high number of deaths resulting from unsafe abortions conducted outside hospitals. Altogether, the total abortion rate is estimated to be 117 per 1000 women.

According to the old legislation women faced sentences up to 20 years if an abortion was considered to have been “infanticide” (rather than miscarriage, for example) and about 20% of women in jails were convicted on charges of abortion. Now, abortion is legal up to 12 weeks for any woman and up to 18 weeks in cases of rape or incest.

Following several years of strong advocacy work with the participation of many different stakeholders, the process of passing the legal text enacting the abortion law through Cabinet took almost two years. To prepare the ground for the implementation of the new law, an abortion task force was constituted under the Family Health Division, with members from the Nepal Society for Obstetricians and Gynaecologists (NESOG), GTZ , the Nepal Safer Motherhood Project (NSMP), and CREHPA (Centre for Research on Environment Health and Population Activities). Its task was to prepare policy, strategy and implementation documents and to train service providers. Key principles were to keep policies simple and to adhere to a “woman-friendly approach”. Financial and technical sup-

port was provided from GTZ, NSMP and Ipas, the main international NGO to mitigate unsafe abortions. International experiences were reviewed, such as the case of India, where many barriers have risen as a result of complex regulation, and South Africa and Guyana, where laws are relatively liberal to minimise barriers. Further lessons learned from international experience were that: advocacy is needed continuously, not only until new abortion laws have passed; progressive laws are not of much use until they can be implemented; and family planning services have to be strengthened at the same time.

Guidelines were drafted based on these experiences as well as on WHO guidelines. Main elements of the implementation strategy were training, service provision, Behaviour Change Communication, monitoring and evaluation. Key interventions were to train gynaecologists and medical practitioners to facilitate the availability of services at district hospitals. It is envisaged at a later stage to also train nurses to enable access of services at primary care facilities. A relatively simple system was used where certification of trainings was given to individual, trained providers rather than health facilities.

Some key lessons to be drawn from the experience in Nepal are that despite traditionally conservative social attitudes, it was possible to convince authorities with effective research, and demonstrating the link between illegal abortion and high maternal mortality. Further, many different stakeholders contributed in different ways, from advocacy of the NGOs, to technical support of donors, and information from international sources. Finally, the lengthy process shows that perseverance, combined with creative use of different initiatives, was necessary for a successful outcome.

Source: Anne Erpelding, MSc
Former Team Leader, RH Component, GTZ Health Sector Support Programme, Kathmandu, NEPAL

References used to produce the update

Chapter Maternal Mortality:

- What is Safe Motherhood ? http://www.who.int/reproductive-health/mps/ http://www.safemotherhood.org/about/whatis_sm.html
- What are priorities of safe motherhood: (incl. skilled attendants, health systems and involving communities) http://www.safemotherhood.org/smpriorities/index.html
- Making pregnancy safer in Eastern Europe/CA http://www.euro.who.int/pregnancy
- Making safe motherhood a reality in West Africa: Using indicators to programme for results http://www.unfpa.org/publications/index.cfm?filterID_Key_Issue=16
- Maternal Mortality Update 2002: A Focus on emergency obstetric care: http://www.unfpa.org/upload/lib_pub_file/201_filename_mmupdate-2002.pdf

Chapter preventing unsafe abortions:

- **IPAS:** Lives worth saving: Abortion care in sub-Saharan Africa since ICPD: A progress report: http://www.ipas.org/publications/en/ICPD/ICPDAfricabooksm_en.pdf
- Reproductive health trends in Eastern Europe and Eurasia: A Comparative Report, Division of Reproductive Health, CDC, US
- "Ensuring Women's Access to Safe Abortion Care in Latin America and the Caribbean", as well as other resources from: www.ipas.com
- Abortion Policies: A Global Review: United Nations Population Development Division http://www.un.org/esa/population/publications/abortion/
- Safe Motherhood Fact Sheets, Family Care International: www.safemotherhood.org

Selected interesting further resources and links

Investing in People: National Progress in Implementing the ICPD Programme of Action 1994-2004. UNFPA This is a global survey to assess the progress of ICPD+10. Based on the information of 169 countries looking at selected aspects of population, gender and reproductive health issues, the Fund prepared a global report on national experiences in implementing the ICPD Programme of Action and Key Actions. http://www.unfpa.org/icpd.

Advance Africa: Best practice compendium for Family Planning and RH, CD Rom, USAID This Website is a resource for FP/RH service delivery, which includes tools and approaches for program managers that strengthen service delivery and coordination, including Strategic Mapping and the Best Practices Compendium, innovative approaches to FP/RH activities, country programs, publications and presentations, l inks to valuable FP/RH information and resources http://www.advanceafrica.org/

Safe abortion: Technical and policy guidance for health systems, WHO, 2003, This technical and policy guidance publication is the outcome of a Technical Consultation of an extensive review of evidence, and of additional review by experts from around the world. This publication should be of use to a wide range of health professionals, and others, who are working to reduce maternal mortality and morbidity. It provides a comprehensive overview of the many actions that can be taken to ensure access to good quality abortion services as allowed by law.
http://www.who.int/reproductive-health/publications/safe_abortion/Safe_Abortion.pdf

Unsafe abortion- global and regional estimates of the incidence of unsafe abortion and associated mortality in 2000, WHO, This Web-Resource provides estimates of regional and global incidence and mortality due to unsafe abortions and information of the data and methods used for the estimates. http://www.who.int/reproductive-health/publications/MSM_97_16/MSM_97_16_table_of_contents_en.html

Prevention of unsafe abortion This website of WHO contains a collection of essential publications and documents with regard to unsafe abortion in different languages.
http://www.who.int/reproductive-health/pages_resources/listing_unsafe_abortion.html

Online course: engender health has developed Web-based and CD-ROM self-instructional courses for health care providers, supervisors, students, and trainers around the world—particularly for those in low-resource settings. One module focuses on maternal and child health, including post-abortion care http://www.engenderhealth.org/res/onc/

MCPC: managing complications in pregnancy and childbirth is a manual of evidence-based guidelines for maternal and neonatal healthcare interventions. The Maternal and Neonatal Health Program uses the MCPC manual as the basis for its clinical training activities and is actively involved in disseminating the manual in MNH Program countries and beyond. The Program is also working with several countries to adapt, approve, disseminate and implement the guidelines outlined in the manual. http://www.who.int/reproductive-health/impac/

Safe Motherhood, This Website presents the Safe Motherhood Initiative, Priorities and International Commitment for Safe Motherhood, and a collection of Information Resources.
http://www.safemotherhood.org/

Maternal Mortality in 2000: Estimates developed by WHO, UNICEF and UNFPA.
http://www.unfpa.org/upload/lib_pub_file/237_filename_maternal_mortality_2000.pdf